85-810

No.

Supreme Court, U.S.
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IN THE

Supreme Court of the United States

OCTOBER TERM 1985

MICHIGAN UNITED FOOD AND COMMERCIAL WORKERS UNIONS AND FOOD EMPLOYERS HEALTH AND WELFARE FUND, and the BOARD OF TRUSTEES thereof; and MICHIGAN UNITED FOOD AND COMMERCIAL WORKERS UNIONS DRUG AND MERCANTILE EMPLOYEES WELFARE FUND, and the BOARD OF TRUSTEES thereof,

Petitioners

v.

NANCY A. BAERWALDT, COMMISSIONER OF INSURANCE OF THE STATE OF MICHIGAN; JEAN CARLSON and THOMAS PIERSON, DEPUTY COMMISSIONERS OF INSURANCE OF THE STATE OF MICHIGAN; and THE BUREAU OF INSURANCE OF THE STATE OF MICHIGAN,

Respondents.

PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT AND APPENDIX

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105

QUESTION PRESENTED

WHETHER UNINSURED EMPLOYEE WELFARE BENEFIT PLANS, WHICH ARE IMMUNE FROM STATE INSURANCE REGULATION UNDER ERISA (*METROPOLITAN LIFE INSURANCE CO.* v. *COMMONWEALTH OF MASSACHUSETTS*, 471 U.S. ——, 105 S. CT. 2380 (1985)), LOSE THEIR IMMUNITY WHEN THEY ACQUIRE CATASTROPHIC BENEFIT LOSS COVERAGE.

TABLE OF CONTENTS

	Page
Opinions Below	2
Jurisdiction	2
Statutes Involved	2
Statement of the Case	2
Reasons for Granting the Petition	5
Conclusion	14
Appendix	1a
A. Opinion of The Sixth Circuit Court of Appeals	1a
B. Opinion of The United States District Court (E.D. Mi.)	11a
C. Judgment of The Sixth Circuit Court of Appeals	30a
D. 1980 PA 429, M.C.L.A. §§ 500.3425, .3609a	31a
E. ERISA Sec. 514, 29 U.S.C. 1144	34a

TABLE OF AUTHORITIES

Cases: *Page*

Alessi v. *Raybestos-Manhattan, Inc.*, 451 U.S. 504 (1981) 5, 9

Cantor v. *Detroit Edison Co.*, 428 U.S. 579 (1976) 13

Dawson v. *Whaland*, 529 F. Supp. 626 (D. N.H. 1982) 10

General Electric Company v. *Gilbert*, 429 U.S. 125 (1976), *reh. den.* 429 U.S. 1079 10

General Motors Corp. v. *California State Board of Equalization*, 600 F. Supp. 76 (C.D. Cal. 1984) 8

Group Life & Health Ins. Co. v. *Royal Drug*, 440 U.S. 205 (1979), *reh. den.*, 441 U.S. 917 10

Metropolitan Insurance Company v. *State Board of Equalization*, 32 Cal. 3d 649, 186 Cal. Reptr. 578, 652 P.2d 426 (1982) 8

Metropolitan Life Insurance Co. v. *Commonwealth of Massachusetts*, 471 U.S. _____, 105 S. Ct. 2380 (1985) ..... *passim*

Nachman Corp. v. *Pension Benefit Guarantee Corp.*, 446 U.S. 359 (1980), *reh. den.*, 448 U.S. 908 13

Schlude v. *Commissioner*, 372 U.S. 128 (1963) 13

SEC v. *Variable Annuity Life Ins. Co.*, 359 U.S. 65 (1959) 10

Shaw v. *Delta Airlines, Inc.*, 463 U.S. 85 (1983) 5, 7, 11

Union Labor Life Insurance Co. v. *Pireno*, 458 U.S. 119 (1982) 7

Wadsworth v. *Whaland*, 562 F.2d 70 (CA 1 1977), *cert. denied*, 435 U.S. 980 (1978) 11

Statutes:

Employee Retirement Income Security Act of 1974, 29 U.S.C. (& Supp.) 1001 *et seq.*

Section 3(1), 29 U.S.C. 1002(1) 3

Section 3(3), 29 U.S.C. 1002(3) 3

	Page
Section 102, 29 U.S.C. 1022	9
Section 104(b), 29 U.S.C. 1024(b)	9
Section 404, 29 U.S.C. 1104	9
Section 502(a)(3), 29 U.S.C. 1132(a)(3)	3
Section 502(f), 29 U.S.C. 1132(f)	3
Section 514, 29 U.S.C. 1144	11, 12
Section 514(a), 29 U.S.C. 1144(a)	9
Section 514(b)(2)(A), 29 U.S.C. 1144(b)(2)(A)	12
Section 514(b)(2)(B), 29 U.S.C. 1144(b)(2)(B)	8, 9
Section 514(b)(6), 29 U.S.C. 1144(b)(6)	11, 12
Labor Management Relations Act of 1947, 29 U.S.C. (& Supp.) 141 *et seq.*	
Section 302(c); 29 U.S.C. 186(c)	2
28 U.S.C. 1254(1)	2
28 U.S.C. 1331(a)	3
28 U.S.C. 1337	3
Michigan Insurance Code of 1956, M.C.L.A § 500.3400 *et seq.*, as amended by 1980 Michigan Public Act No. 429	
M.C.L.A. § 500.3425	2
M.C.L.A. § 500.3609a	2

Miscellaneous:

Arnett & Trapnell, *Private Health Insurance: New Measures of a Complex and Changing Industry,* 6 Health Care Financing Review 31 (1984)	6, 10
Cain, *Large, Small Self-Insurers' Techniques Differ,* 17 *Business Insurance* 11 (Jan. 31, 1983)	6
Fossett, *Self-Insured Group Plans Examined,* National Underwriter: Life and Health Insurance, May 1, 1982, at 18-19	6
Geisel, *Surveys Find Most Employers Self-funding Health Benefits,* 19 Business Insurance, 3, 10-11 (Jan. 1, 1985)	6

	Page
Kilberg & Inman, *Preemption of State Laws Relating to Employee Benefit Plans: An Analysis of ERISA Section 514*, 62 Tex. L. Rev. 1313 (1984)	12
Fed. R. Civ. P. Rule 56	4
Conference Committee Report, 97th Cong. 2d sess., 128 Cong. Rec. H. 10650 (daily ed. Dec. 21, 1982)	12
120 Cong. Rec. 29197 (Aug. 20, 1974)	7, 11

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v.

NANCY A. BAERWALDT, COMMISSIONER OF INSURANCE OF THE STATE OF MICHIGAN; JEAN CARLSON and THOMAS PIERSON, DEPUTY COMMISSIONERS OF INSURANCE OF THE STATE OF MICHIGAN; and THE BUREAU OF INSURANCE OF THE STATE OF MICHIGAN,

Respondents.

PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

The Michigan United Food and Commercial Workers Unions and Food Employers Health and Welfare Fund, and its Board of Trustees, and the Michigan United Food and Commercial Workers Unions Drug and Mercantile Employees Welfare Fund, and its Board of Trustees,[1] by counsel, respectfully pray that the Court grant the Petition for Writ of Certiorari.

[1]Hereafter referred to as "The Funds". Respondents Nancy A. Baerwaldt, Commissioner of Insurance of the State of Michigan, and Jean Carlson and Thomas Pierson, Deputy Commissioners of Insurance of the State of Michigan, and the Bureau of Insurance of the State of Michigan, are hereafter referred to as "the Commissioner."

OPINIONS BELOW

The opinion of the Sixth Circuit Court of Appeals (App., *infra*, pp. 1a-7a), is reported at 767 F.2d 308 (CA 6 1985).[2] The opinion of the District Court for the Eastern District of Michigan (App., *infra*, pp. 8a-19a) is reported at 572 F. Supp. 943 (E.D. Mi. 1983).

JURISDICTION

The judgment of the Court of Appeals for the Sixth Circuit was made and entered on July 19, 1985, and a copy thereof is appended to this petition (App., *infra*, p. 20a). The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATUTES INVOLVED

The pertinent provisions of 1980 PA 429, amending the Michigan Insurance Code, Michigan Comp. Laws Ann. (M.C.L.A.) §§ 500.3425, .3609a; and of Section 514 of ERISA, 29 U.S.C. 1144, are set forth in the Appendix, *infra*, pp. 21a-23a.

STATEMENT OF THE CASE

In 1980, the Michigan Legislature enacted 1980 Michigan Public Act No. 429, Michigan Comp. Laws Ann. (M.C.L.A.) §§ 500.3425, .3609a (1983), amending the state Insurance Code (App., *infra*, pp. 21a-22a). Act 429 requires every insurer offering health insurance policies in Michigan to provide specified levels of coverage for substance abuse.

Plaintiffs are employee benefit trust funds established under Sec. 302(c) of the Labor Management Relations Act of 1947, as amended, 29 U.S.C. 186(c), to provide health and welfare benefits to covered employees of contributing employers in the supermarket and in the drug and mercantile industries in Michigan. The Funds are "employee benefit plans" as defined

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[2]The parties to the proceedings below in the Sixth Circuit Court of Appeals are as set forth in the caption of this case, *supra*.

in Sec. 3(3) of ERISA, 29 U.S.C. 1002(3), and "employee welfare benefit plans" as defined in Sec. 3(1) of ERISA, 29 U.S.C. 1002(1).

The plaintiff Boards of Trustees of each Fund have entered into "Flexible Funding Plan Agreements" with the Transamerica Occidental Life Insurance Company. Under this arrangement, the Funds are "self-insured" (i.e., self-funded) up to a trigger point, called the "claims liability limit," which is a specified annual aggregate dollar amount of claims beyond which the carrier covers excess or catastrophic loss.[3] The "claims liability limit" has never been reached during the history of these agreements. The Funds adjudicate claims and payments are made from accounts in the Funds' names; the carrier provides administrative support services, actuarial accounting, and preparation of plan description booklets, which, *inter alia*, inform participants that the Funds are not insured below the "claims liability limit."

The Funds provide benefits for alcoholism and drug abuse treatment, but not to the extent mandated by 1980 PA 429. On October 12, 1982, plaintiffs filed a complaint[4] in the United States District Court, Eastern District of Michigan, naming as defendant Nancy A. Baerwaldt, the Insurance Commissioner of the State of Michigan. The complaint alleged that 1980 PA 429 was preempted by ERISA as applied to the Funds, and sought declaratory and injunctive relief prohibiting the Insurance Commissioner from applying the requirements of 1980 PA 429 to the Funds' agreements with Transamerica Occidental. Jurisdiction of the District Court was based on 28 U.S.C. 1331(a) and 1337, and ERISA Sec. 502(a)(3) and (f), 29 U.S.C. 1132(a)(3) and (f).

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[3]There is a "claims liability limit" applicable to individual claims, beyond which there is similar catastrophic loss coverage.

[4]An amended complaint filed on April 13, 1983, added the Boards of Trustees of the Funds as plaintiffs.

The defendant moved to dismiss, and plaintiff Funds moved for summary judgment pursuant to Fed. R. Civ. P. Rule 56. The Hon. John Feikens, Chief District Judge, issued an opinion on June 16, 1983, denying the motion to dismiss and granting summary judgment for the plaintiffs (App., *infra*, pp. 8a-19a). The court held 1980 PA 429 preempted by ERISA as an impermissible indirect regulation of the terms of an employee benefit plan.

Defendant appealed to the Sixth Circuit Court of Appeals. On June 3, 1985, after briefs and oral arguments had been submitted to the Court of Appeals, this Court issued its decision in *Metropolitan Life Insurance Co.* v. *Commonwealth of Massachusetts*, 471 U.S. —, 105 S.Ct. 2380 (1985). On July 19, 1985, without further briefing or argument, the Sixth Circuit Court of Appeals issued its opinion, reversing the District Court and remanding for further proceedings (App., *infra*, pp. 1a-7a). The Sixth Circuit held that 1980 PA 429 is not preempted by ERISA. The Court stated first that the holding of *Metropolitan Life, supra*, is controlling, since that case "presented precisely the issue that confronts us in the case at bar and upheld the challenged statute." (App., *infra*, p. 5a). Next, the Court acknowledged that the "stop-loss" nature of the Funds' insurance policies presented an additional question, but a question the court could summarily decide: "The 'stop-loss' nature of the plans does not alter our conclusion. . . . As long as the plans purchase insurance from 'an insurer offering health insurance policies in' Michigan, the policies must include the substance abuse coverage specified by Act 429." (App., *infra*, pp. 5a-6a).[5]

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[5]The Sixth Circuit also held 1980 PA 429 not preempted by the National Labor Relations Act, citing *Metropolitan Life, supra*. The District Court had added NLRA preemption of the Michigan law as an alternative basis for summary judgment (App., *infra*, pp. 18a-19a).

REASONS FOR GRANTING THE PETITION

Six weeks after this Court clarified complex and important issues of ERISA preemption in *Metropolitan Life Insurance Co.* v. *Massachusetts, supra*, the Sixth Circuit issued a decision which muddies the waters so recently calmed by this Court. Holding Michigan Public Act 429 applicable to self-funded and essentially self-insured employee welfare plans, by virtue of the plans' "excess loss" insurance coverage, the Court of Appeals has distorted the differentiation between "uninsured" — and therefore ERISA preempted — and "insured" — and therefore not preempted — plans elucidated in *Metropolitan Life, supra*[6] — with the impermissible result that ERISA's "insurance savings" exception swallows the rule of broad ERISA preemption. "ERISA's authors clearly meant to preclude the states from avoiding through form the substance of the preemption provision." *Alessi* v. *Raybestos-Manhattan, Inc.*, 451 U.S. 504, 525 (1981).

The court below has decided a most important federal question in a manner that conflicts with the teaching of *Metropolitan Life, supra*, and departs from the consistent interpretation of ERISA Section 514 as mandating broad federal preemption subject to narrow enumerated exceptions. *See, Shaw* v. *Delta Airlines, Inc.*, 463 U.S. 85, (1983).

The impact of the Sixth Circuit's misapplication of *Metropolitan Life* will be extensive. The involvement of insurance providers in the funding and administration of employee welfare benefit plans covers a broad spectrum from provision of "administrative services only" ("ASO"), to various combined insured-uninsured arrangements ("excess loss" coverage, "min-

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[6] "We are aware that our decision results in a distinction between insured and uninsured plans, leaving the former open to indirect regulation while the latter are not. By so doing we merely give life to a distinction created by Congress in the 'deemer clause,' a distinction Congress is aware of and one it has chosen not to alter."
Metropolitan Life, supra, 471 U.S. at __ , 105 S. Ct. at 2393.

imum premium" plans), to full conventional insurance. *See,* Arnett & Trapnell, *Private Health Insurance: New Measures of a Complex and Changing Industry,* 6 Health Care Financing Review 31 (1984). A growing number of self-funded and primarily self-insured employee welfare benefit plans, such as the plaintiff UFCW Funds, purchase "excess risk," "stop-loss," or "minimum premium" insurance coverage (60.9% of the sample in one recent survey of single employer plans). Geisel, *Surveys Find Most Employers Self-funding Health Benefits,* 19 Business Insurance, 3, 10-11 (Jan. 1, 1985). These arrangements allow the plans to self-insure, while enabling fiduciaries to protect assets from catastrophic depletion. Fossett, *Self-Insurance Group Plans Examined,* National Underwriter: Life and Health Insurance, May 1, 1982, at 18-19; Cain, *Large, Small Self-Insurers' Techniques Differ,* 17 *Business Insurance* 11 (Jan. 31, 1983).

Under the Sixth Circuit's simplistic analysis, these plans in their various configurations are indiscriminately affected by state regulation of terms and benefit levels solely by virtue of insurance policies underwriting marginal risks. In fact, under that analysis, only approximately *eighteen percent* of the employee health care market — those totally self-insured plans without any purchased insurance coverage — will be subject to the exclusive federal regulation of terms and benefits mandated by Sec. 514(a) of ERISA! *See,* Arnett & Trapnell, *supra,* at pp. 34-35.[7]

The Funds submit, for the reasons stated below, that the Court of Appeals has misconstrued the instruction of *Metropolitan Life,* to reach a result that is discordant with ERISA and with applicable legal precedent. It is a result that will, if allowed to stand uncorrected, fundamentally undermine the

[7] "Some companies assume all the risk and totally self-fund their health care coverages without stop-loss insurance but this number is believed to be small." Geisel, *supra,* at p. 11.

Concededly, the Sixth Circuit's ruling would not affect self-funded plans which *reinsure* any of their risks (with or without administrative services by an insurance carrier).

supremacy of federal regulation of employee welfare benefit plans — the "crowning achievement" of ERISA. Remarks of Rep. Dent, 120 Cong, Rec. 29197 (Aug. 20, 1974) quoted at *Shaw* v. *Delta Air Lines, Inc., supra,* 463 U.S. at 99.

I

THE OPINION BELOW IS AMBIGUOUS, UNWORKABLE AND IN CONFLICT WITH APPLICABLE PRECEDENT.

The Funds, through their "Flexible Funding" arrangement with Transamerica Occidental Life Insurance Company, are in fact primarily uninsured, and only marginally insured. Up to an aggregate amount dollar amount of claims (the "claims liability limit"), the Funds are self-insured; they administer and adjudicate claims, they bear the liability for payment, and claimants or providers are paid directly from a separate account of the Funds. When aggregate claims exceed the "claims liability limit" (a contingency which has never occurred), the Funds are no longer self-insured; Transamerica then assumes liability and payments are made to claimants and providers from Transamerica's accounts.

The Funds' contract with Transamerica is one of many varieties of "excess loss" or "minimum premium" coverage purchased by self-funded employee welfare benefit plans. The Sixth Circuit erroneously sidesteps a complex issue by indiscriminately characterizing the Funds as "insured," *despite* the fact that they are essentially *self-funded* or *self-insured*, with a separable insured component.

The Sixth Circuit's conclusion that the mere existence of an "excess loss" insurance contract transforms the Funds into "insured" funds for the purpose of ERISA preemption is contrary to law and common sense. It is well settled that the extent of insurance coverage is congruent with the extent of risk assumed by the insurer, as defined by the contract between the insurer and policyholder. *Union Labor Life Insurance Co.* v. *Pireno*, 458 U.S. 119, 130 (1982). The uninsured and insured

portions are therefore separable components of the Funds' liability. *See, General Motors Corp.* v. *California State Board of Equalization*, 600 F. Supp. 76 (C.D. Cal. 1984); *cf., Metropolitan Insurance Company* v. *State Board of Equalization*, 32 Cal. 3d 649, 186 Cal. Reptr. 578, 652 P. 2d 426 (Cal. 1982). To the extent that claims do not reach the aggregate limit, the Funds are uninsured, and to that extent indirect state regulation of the Funds through insurance law is preempted by ERISA. *Metropolitan Life, supra.*[8]

The respondent insurance commissioner evidently interprets the Sixth Circuit's opinion to hold that Act 429 is deemed applicable *to the Fund as a whole*, not merely to *the insurer's coverage of excess claims*. Petitioners disagree with that construction. However, when the Court of Appeals remanded for further proceedings, it failed to clearly state the law of the case, providing inadequate guidance for the parties or the court below. By any reading of its holding, the Court of Appeals has misapplied applicable precedent.

Petitioners respectfully submit that if the court intended to hold Act 429 applicable to the *uninsured* portion of the Funds' operations, it committed fundamental error. The Funds bear the risk and liability, and they administer, adjudicate, and pay all claims up to a predetermined level; if the Funds are not "uninsured" to this extent, it is difficult to imagine what employee welfare benefit plan, under that construction of the Sixth Circuit's analysis, *would* fall within ERISA's broad preemption clause. State regulatory authority cannot be extended to the uninsured portion of the Fund's liability without completely eviscerating ERISA's "deemer clause," which specifically prohibits the designation of an employee benefit plan "as an insurance company or insurer . . . for purposes of any law of a state purporting to regulate insurance companies. . . ." ERISA Sec.

[8]In actual experience, the claims liability limit has never been reached. Historically, therefore, all payments to beneficiaries and providers have been made by the Funds themselves.

514(b)(2)(B), 29 U.S.C. 1144(B)(2)(B). Imposing the State's minimums on the Fund's *uninsured* benefits would contravene the fundamental ERISA principle that "the private parties, not the government, control the level of benefits." *Alessi* v. *Raybestos-Manhattan, Inc.*, 451 U.S. 504, 511 (1981).

Petitioner's alternative reading of the Sixth Circuit's decision, holding Act 429 not preempted only to the extent of the Funds' insurance coverage, nevertheless leads to problematical results. Administration of the Funds subject to the State's mandated benefits requirements *only* to the extent of Transamerica Occidental's excess loss policy would be impracticable, given the resultant conditioning of mandated benefits on an extraneous event not ascertainable at the time coverage is determined. Application of 1980 PA 429 to the contingent insured portion of the Funds' benefits liability would, at best, seriously impair the trustees' ability to satisfy their fiduciary and statutory responsibilities for sound actuarial planning and for full disclosure of coverage to plan participants (as required by ERISA, 29 U.S.C. 1022, 1024(b), 1104) — at worst, it would create an administrative imbroglio.

The Sixth Circuit's opinion is insufficiently clear as to which, if either, of the results discussed above is contemplated; although petitioners submit it is the second, both are legally and practically unsound. The Court should therefore grant this petition and rectify the Sixth Circuit's deviation from *Metropolitan Life, supra.*

II.

THE FUNDS ARE EFFECTIVELY UNINSURED FOR PURPOSES OF ERISA PREEMPTION

The optimal approach to resolving the confusion of the opinion below and harmonizing it with the principles announced in *Metropolitan Life, supra*, is to acknowledge that the Funds are *effectively uninsured*, and therefore sheltered by ERISA preemption, Sections 514(a) and (b)(2)(B); 29 U.S.C. 1144(a), 1144(b)(2)(B).

Employee benefit plans with insurance coverage and premium structures identical to the plaintiff Funds' have consistently been treated as *self-insured*. Observing the employer's "Sickness and Accident Insurance Plan" in *General Electric Company* v. *Gilbert*, 429 U.S. 125 (1976), *reh. den.*, 429 U.S. 1079, this Court stated:

> With respect to the Plan, General Electric is, in effect, a self-insurer. While General Electric has obtained, for employees outside California, an insurance policy from the Metropolitan Life Insurance Co., this policy involves the payment of a tentative premium only, subject to adjustment in the light of actual experience . . . *In effect, therefore, the Metropolitan Life Insurance Co. is used to provide administrative service of processing claims, while General Electric remains, for all practical purposes, a self-insurer.*

Id., at 128, n. 3 (emphasis added); *see also, Dawson* v. *Whaland*, 529 F. Supp. 626 nn. 3, 4 (D. N.H. 1982). The adjustable premium described by the Court above is almost identical to the "Flexible Funding" premium arrangement between the Funds and Transamerica.[9]

The Court recognized in *General Electric* v. *Gilbert, supra*, that an experience-rated premium arrangement such as the one between the Funds and Transamerica transfers only minimal actual risk to the insurer -- primarily liability for cancellation with an accumulated deficit. *See*, Arnett & Trapnell, *supra*, at p. 29.

An insurance policy is not an infallible indicator of insurance. *SEC* v. *Variable Annuity Life Ins. Co.*, 359 U.S. 65 (1959). A policyholder is insured only to the extent of the risk actually underwritten. *Group Life & Health Ins. Co.* v. *Royal Drug*, 440 U.S. 205 (1979), *reh. den.* 441 U.S. 917. In the case of the Funds, that risk is negligible — certainly a slim reed upon

[9]A portion of the premium that covers insurance of excess individual claims is not experience rated. The excess coverage for individual liability, like that for aggregate liability, see footnote 8, *supra*, has never been subject to claim.

which to circumvent the "crowning achievement" of ERISA, "the reservation to federal authority of the sole power to regulate the field of employee benefit plans, . . . [protecting] participants by eliminating the threat of conflicting and inconsistent state and local regulation." Remarks of Sen. Dent, 120 Cong. Rec. 29197 (Aug. 20, 1974), quoted at *Shaw* v. *Delta Airlines, Inc., supra,* 463 U.S. at 99.

To the extent that the Funds are essentially self-insured, with supplemental insurance coverage solely on a contingent "excess loss" basis, they should be considered ***uninsured.*** (Compared with the plans providing approximately 90 percent of benefits through group insurance policies, described in *Wadsworth* v. *Whaland*, 562 F.2d 70, 75 (CA 1 1977), *cert. denied*, 435 U.S. 980 (1978), the UFCW Funds have, to date, provided no benefits through "excess-loss" insurance.)

Congress has indicated the proper approach to distinguishing plans that are effectively uninsured or marginally insured, from those that fund benefits primarily through conventional purchased insurance policies, in relation to federal preemption of state regulation. In 1982, out of concern over underfunding of multiple employer health insurance trusts (which the Funds do not claim to be), Congress amended Sec. 514 to codify an explicit exemption from ERISA preemption. Sec. 514(b)(6), 29 U.S.C. 1144(b)(6)[10] In that legislation, Congress explicitly

[10]Sec. 514(b)(6)(A) — Notwithstanding any other provision of this section

(i) in the case of an employee welfare benefit plan which is a multiple employer welfare arrangement and is fully insured (or which is a multiple employer welfare arrangement subject to an exemption under subparagraph (B)), any law of any State which regulates insurance may apply to such arrangement to the extent that such law provides —

(I) standards, requiring the maintenance of specified levels of reserves and specified levels of contributions, which any such plan, or any trust established under such a plan, must meet in order to be considered under such law able to pay benefits in full when due, and

(II) provisions to enforce such standards, and

(ii) in the case of any other employee welfare benefit plan which is a multiple employer welfare arrangaement, in addition to this title, any

Continued on page 12

distinguished "fully insured" multiple employer welfare arrangements from plans that are not fully insured. In Sec. 514(b)(6)(A)(i), state insurance regulation of fully insured plans is preempted, with limited exceptions; conversely, Sec. 514(b)(6)(A)(ii) expressly permits the states to regulate multiple employer welfare arrangements that are not fully insured directly through their insurance laws. *See, Conference Committee Report*, 97th Cong., 2d Sess., 128 Cong. Rec. H. 10650 (daily ed. Dec. 21, 1982).

The obvious rationale is that an express grant of state authority to regulate fully-insured plans was unnecessary, because the "insurance savings clause," Sec. 514(b)(2)(A), 29 U.S.C. 1144(b)(2)(A), permits the states to guarantee the financial integrity of such plans indirectly through regulation of their principal asset — the insurance policy. Where Congress intended to permit an exception to ERISA's preemption of state regulation of partially insured (or effectively non-insured) plans through insurance laws, it expressly said so, in Sec. 514(b)(6)(A)(ii). That section would be superfluous if, as the Court of Appeals holds, the states could already regulate the terms of partially-insured plans through their insurance carriers under the preceding provisions of Section 514. *See*, Kilberg & Inman, *Preemption of State Laws Relating to Employee Benefit Plans: An Analysis of ERISA Section 514*, 62 Tex. L. Rev., 1313, 1319 (1984).

Continued from page 11

> law of any State which regulates insurance may apply to the extent not inconsistent with the preceding sections of this title.
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> • • •
>
> (D) For purposes of this paragraph, a multiple employer welfare arrangement shall be considered fully insured only if the terms of the arrangement provide for benefits the amount of all of which the Secretary determines are guaranteed under a contract, or policy of insurance, issued by an insurance company, insurance service, or insurance organization, qualified to conduct business in a State.

29 U.S.C. 1144 (b)(6).

By designating the Funds as "insured," and consequently subject to Michigan's mandated substance-abuse coverage law — even as to the excess coverage — the Sixth Circuit has misconstrued, misapplied, and "misapprehended the scope" of the holding in *Metropolitan Life*. Intervention and reversal by this Court is therefore appropriate. *See, e.g., Schlude* v. *Commissioner*, 372 U.S.. 128, 129-30 (1963); *Cantor* v. *Detroit Edison Co.*, 428 U.S. 579, 581 (1976). An approach which acknowledges the "comprehensive and reticulated" structure of ERISA, *Nachman Corp.* v. *Pension Benefit Guarantee Corp.*, 446 U.S. 359, 361 (1980), *reh. den.* 448 U.S. 908, harmonizing Congress' desire for broad federal preemption with its solicitude for local insurance regulation, is one which treats marginally insured plans as effectively *uninsured* and reserves for state insurance regulation those plans which maintain as their principal security an insurance policy.

CONCLUSION

The petition for a writ of certiorari should be granted. The Court of Appeals has misapplied the recent holding in *Metropolitan Life, supra*, and in so doing has decided an important federal preemption question contrary to applicable decisions of this Court.

Respectfully submitted,

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October 15, 1985

APPENDIX

A. Opinion of the United States Court of Appeals for the Sixth Circuit, *Michigan United Food and Commercial Workers Unions and Food Employers Health and Welfare Fund, et al.* v *Nancy A. Baerwaldt, et al.*, 767 F.2d 308, Case No. 83-1570, July 19, 1985.

No. 83-1570.

UNITED STATES COURT OF APPEALS

Sixth Circuit.

Argued Sept. 18, 1984

Decided July 19, 1985.

MICHIGAN UNITED FOOD AND COMMERCIAL WORKERS UNIONS and Food Employers Health and Welfare Fund, and the Board of Trustees thereof; and Michigan United Food and Commercial Workers Unions Drug and Mercantile Employees Welfare Fund, and the Board of Trustees thereof, Plaintiffs-Appellees,

v.

NANCY A. BAERWALDT, Commissioner of Insurance of the State of Michigan; Jean Carlson and Thomas Pierson, Deputy Commissioners of Insurance of the State of Michigan; and the Bureau of Insurance of the State of Michigan, Defendants-Appellants.

Frank J. Kelley, Atty. Gen. of Mich., Lansing, Mich., William A. Chenoweth, Asst. Atty. Gen. (argued), for defendants-appellants.

Theodore Sachs (argued), Detroit, Mich., for plaintiffs-appellees.

Before KEITH, Circuit Judge, and PECK and BROWN, Senior Circuit Judges.

BAILEY BROWN, Senior Circuit Judge.

Plaintiffs are two voluntary, unincorporated employee benefit trust funds, and the trustees thereof. The plaintiff plans were

established to provide health and welfare benefits to participating union employees and their beneficiaries and are "employee welfare benefit plans" as defined by the Employee Retirement Income Security Act (ERISA), 29 U.S.C. §§ 1001-1461. Defendants are the Michigan Bureau of Insurance, Michigan's Commissioner of Insurance and her deputy commissioners.

The plaintiffs brought this action seeking to invalidate Michigan Public Act 429 of 1980, which required that all health insurance policies issued in Michigan provide certain levels of substance abuse coverage. Plaintiffs contended that Act 429, as applied to plaintiffs, was pre-empted by ERISA and therefore was unconstitutional under the Supremacy Clause. Plaintiffs also contended that Act 429 impermissibly interfered with the freedom of unions and employers to bargain freely and therefore was pre-empted by the National Labor Relations Act (NLRA).

The district court, 572 F.Supp. 943 (D.C. Mich. 1983), granted plaintiffs' motion for summary judgment and held that Public Act 429 was pre-empted by both the ERISA and the NLRA. In light of the Supreme Court's recent opinion dealing directly with these issues, *Metropolitan Life Insurance Company* v. *Massachusetts*, —— U.S. ——, 105 S.Ct. 2380, 85 L.Ed.2d 728 (1985), we reverse.

I

The plaintiff plans are voluntary, unincorporated employee benefit trust funds established pursuant to the Labor Management Relations Act for the purpose of providing health and welfare benefits to covered employees of participating employers and their dependents. To accomplish this goal, the plans purchased group insurance policies from insurer Transamerica Occidental Life Insurance Company (Occidental). Through a contract with Occidental, the plans pay all the health and welfare benefits provided under the group policies up to an

agreed upon amount (termed "claims liability limit"). After the claims liability limit is reached, Occidental is liable for payment of additional benefits under the applicable policies. Thus, the plaintiff plans are self insured up to the claims liability limit, beyond which they are insured for excess or catastrophic loss. Occidental does, however, fully administer the plans as agent for the plans.

This action was precipitated by the Michigan legislature's enactment of 1980 Michigan Public Act No. 429, which required every insurer offering health insurance policies within the state to provide coverage for substance abuse. Mich.Comp.Laws Ann. § 500.3425 (1983).[1] Act 429 was enacted as part of Michigan's continuing effort to deal with the problem of drug and alcohol abuse. The state estimates that approximately 750,000 of its citizens need services for drug abuse problems. In addition to the human suffering associated with drug and alcohol abuse, substance abuse results in absenteeism, increased health and welfare expenditures, property damage and accidents, and medical expenses — the annual cost of which is estimated to approach two billion dollars in Michigan alone. Additionally, the cost of lost productivity stemming from substance abuse exceeds $700 million annually in Michigan. By requiring that all insurance policies issued within the state provide specified levels of substance abuse coverage, the state hoped to encourage earlier treatment of drug and alcohol problems and to decrease the cost of abuse coverage by spreading the cost across a larger population.[2]

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[1] Act 429 provides in part:

Each insurer offering health insurance policies in this state shall provide coverage for intermediate and outpatient care for substance abuse, upon issuance or renewal, in all contracts for, group and individual hospital, medical, surgical expense-incurred health insurance policies other than limited classification policies.

Mich.Comp.Laws Ann. § 500.3425(1) (1983).

[2] If the statutorily required substance abuse coverage increased the premium cost by three percent or more, then Act 429 provides that the master policy holder has the option of declining the increased substance abuse coverage. Mich.Comp.Laws Ann. § 500.3425(2) (1983).

Although the plaintiff plans include some coverage for substance abuse treatment, the plans do not meet the requirements of Act 429. Fearing loss of its ability to do business in Michigan, Occidental informed the plaintiff plans that Occidental intended to require the plans to include the benefits specified in Act 429, contrary to the wishes of the plans' trustees. Because the plans' trustees did not wish to amend the plans in compliance with Act 429, plaintiffs filed this action against the Michigan Commissioner of Insurance and others, seeking a declaratory judgment that Act 429 is preempted by ERISA and the NLRA and therefore is inapplicable to the plaintiff plans.

II.

ERISA, 29 U.S.C. §§ 1001-1461, is a comprehensive statutory scheme designed to promote and protect the interests of employees and their beneficiaries in employee benefit plans.[3] See 29 U.S.C. § 1001. In formulating ERISA, Congress imposed upon welfare benefit plans a number of reporting and disclosure requirements, 29 U.S.C. §§ 1021-1031, 1101-1104; but Congress did "not attempt to regulate the substantive content of welfare-benefit plans," *Metropolitan Life Insurance Company v. Massachusetts*, —— U.S. ——, ——, 105 S.Ct. 2380, 2385, 85 L.Ed.2d

[3]An "employee welfare benefit plan" is any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund or program was established or maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services, or (B) any benefit described in section 186(c) of this title (other than pensions on retirement or death, and insurance to provide such pensions).
29 U.S.C. § 1002(1).
An "employee benefit plan" or "plan" means an employee welfare benefit plan or an employee pension benefit plan or a plan which is both an employee welfare benefit plan and an employee pension benefit plan.
29 U.S.C. § 1002(3).

728 (1985). Although ERISA does not dictate the substantive content of welfare benefit plans, ERISA does contain a broad preemption clause providing that, unless certain exceptions apply, ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." 29 U.S.C. § 1144(a).[4] This ostensibly broad pre-emption clause is limited, however, by an insurance saving clause, 29 U.S.C. § 1144(b)(2)(A). The insurance saving clause states that, with one exception, nothing in ERISA "shall be construed to exempt or relieve any person from the law of any State which regulates insurance, banking, or securities." 29 U.S.C. § 1144(b)(2)(A).

Even a cursory reading of both the preemption clause and the saving clause reveals the conflict between them. While the pre-emption clause dictates that ERISA supersede all state laws relating to employee benefit plans, which plans include insurance benefits, the saving clause dictates that ERISA not be construed to excuse compliance with state insurance laws. The complication created by this conflict is further confused by the deemer clause, an exception to the saving clause. The deemer clause states:

> Neither an employee benefit plan . . . nor any trust

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[4] 1144. *Other Laws*

(a) [PRE-EMPTION CLAUSE] Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. . . . (b)(2)(A) [SAVING CLAUSE] Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

(B) [DEEMER CLAUSE] Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title . . ., nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking *for purposes of any law of any State purporting to regulate* insurance companies, *insurance contracts,* banks, trust companies, or investment companies.

29 U.S.C. § 1144(b)(2)(B) (emphasis added).

As can be gathered from this skeletal recital of ERISA's pertinent passages, portions of the Act are convoluted and seemingly contradictory. We find ourselves able to resolve ERISA's internal conflicts, however, because the Supreme Court has explicitly laid out a trial [sic] for us. In *Metropolitan Life Insurance Company v. Massachusetts,* —— U.S. ——, 105 S.Ct. 2380, 85 L.Ed.2d 728 (1985), the Supreme Court faced precisely the issue that confronts us in the case at bar and upheld the challenged state statute. The Commonwealth of Massachusetts had enacted a statute requiring that all insurance policies issued to Massachusetts residents provide certain levels of coverage for the treatment of mental illness. The Massachusetts statute was challenged by insurance companies that contended that the statute was preempted by both ERISA and the NLRA, and thus was invalid. Justice Blackmun, writing for a unanimous court,[5] first noted that states had long regulated insurance, including group health insurance. The Massachusetts insurance statute was characterized by the Court as a "mandated-benefit law," which requires "an insurer to provide a certain kind of benefit to cover a specified illness or procedure whenever someone purchases a certain kind of insurance." *Id.* at —— , 105 S.Ct. at 2383. The Court concluded that the Massachusetts mandated-benefit law related to an employee benefit plan within the meaning of the pre-emption clause, 29 U.S.C. § 1144(a). *Id.* at ——, 105 S.Ct. at 2388. The Court also

[5]Because Justice Powell did not take part in the decision, the vote was 8-0.

found that the Massachusetts mandated-benefit law regulated the terms of certain insurance contracts and therefore seemed to be saved from pre-emption by the saving clause because the statute was a law "which regulates insurance," 29 U.S.C. § 1144(b)(2)(A). *Id.* Acknowledging that the preemption and the saving clauses were "not a model of legislative drafting," *Id.*, the Court then explored the saving clause and its relationship to the deemer clause and concluded that:

> [b]y exempting from the saving clause laws regulating insurance contracts that apply directly to benefit plans, the deemer clause makes explicit Congress' intention to include laws that regulate insurance contracts within the scope of the insurance laws preserved by the saving clause. Unless Congress intended to include laws regulating insurance contracts within the scope of the insurance saving clause, it would have been unnecessary for the deemer clause explicitly to exempt such laws from the saving clause when they are applied directly to benefit plans.

Id. at ——, 105 S.Ct. at 2390. The Court then held that "mandated-benefit laws . . . are saved from pre-emption by the operation of the saving clause," *Id.* at ——, 105 S.Ct. at 2392 (footnote omitted); therefore, "[i]f a state law 'regulates insurance,' as mandated-benefit laws do, it is not preempted [by ERISA]." *Id.* at ——, 105 S.Ct. at 2393.

As further support for its conclusion that the Massachusetts mandated-benefit law was a valid exercise of state power, the Court looked to the McCarran-Ferguson Act, 15 U.S.C. §§ 1011-1015, which states in part:

> No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance . . .

15 U.S.C. § 1012(b). The Court found that "mandated-benefit laws are state regulation of the 'business of insurance'" within the meaning of the McCarren-Ferguson Act and thus are a

legitimate means for state legislation. —— U.S. at ——, 105 S.Ct. at 2390.

Applying the Supreme Court's reasoning to the case at bar, we can only conclude that Act 429, by virtue of ERISA's saving clause, is not pre-empted by ERISA. Like the Massachusetts statute, Act 429 is a mandated-benefit law, and as such is saved from federal pre-emption by ERISA's saving clause. *Metropolitan Life Insurance Company* v. *Massachusetts*, —— U.S. at ——, 105 S.Ct. at 2392. We hold therefore that Act 429 is not preempted by ERISA. The "stop-loss" nature of the plans does not alter our conclusion. As the Supreme Court recognized, the *Metropolitan Life* decision "results in a distinction between insured and uninsured plans, leaving the former open to indirect regulation while the latter are not." *Id.* According to the Complaint's description of the plans, the plans include an arrangement whereby the plans pay premiums to Occidental to insure that Occidental will pay all benefits in excess of the claims liability limit under the group policies. As long as the plans purchase insurance from "an insurer offering health insurance policies in" Michigan, the policies must include the substance abuse coverage specified by Act 429.

III.

We now turn to the second major issue on appeal. In granting the plaintiffs' motion for summary judgment, the district court stated in a footnote that an alternative basis for invalidating Act 429 was that, in the district court's view, Act 429 was pre-empted by the NLRA, 29 U.S.C. § 151 *et seq.* We hold that, on the contrary, Act 429 is not pre-empted by the NLRA.

Whether mandated-benefit laws deprive parties of the right to negotiate freely the terms of their collective bargaining agreement and thus are pre-empted by the NLRA was also determined by the Supreme Court in *Metropolitan Life Insurance Company* v. *Massachusetts*, —— U.S. ——, 105 S.Ct. 2380,

85 L.Ed.2d 728 (1985). The Court recognized that unionized workers and employers are subject to minimum labor standards imposed by both federal and state law. *Id.* at ——, 105 S.Ct. at 2396.

> [These] minimum state labor standards affect union and non-union employees equally, and neither encourage nor discourage the collective-bargaining processes that are the subject of the NLRA. Nor do they have any but the most indirect effect on the right of self-organization established in the Act. Unlike the NLRA, mandated-benefit laws are not designed to encourage or discourage employees in the promotion of their interests collectively; rather, they are in part "designed to give specific minimum protections to *individual* workers and to ensure that *each* employee covered by the Act would receive" the mandated health insurance coverage.

Id. (quoting *Barrentine* v. *Arkansas Best-Freight System, Inc.*, 450 U.S. 728, 739, 101 S.Ct. 1437, 1444, 67 L.Ed.2d 641 (1981)) (emphasis in original). Furthermore, the NLRA's legislative history does not suggest:

> that Congress intended to disturb the myriad state laws then in existence that set minimum standards, but were unrelated in any way to the processes of bargaining or self-organization. To the contrary, . . . Congress developed the framework for self-organization and collective bargaining of the NLRA within the larger body of state law promoting public health and safety.

Id. at ——, 105 S.Ct. at 2398. Because the purpose of Massachusetts' mandated-benefit law was to implement the Commonwealth's policy of providing mental health care to its residents, the Court found the law was a "valid and unexceptional exercise" of Massachusetts' police power. *Id.* at ——, 105S.Ct. at 2399. The Court concluded that Massachusetts' mandated-benefit law, "like many laws affecting terms of employment, potentially limits an employee's right to choose one thing by requiring

that he be provided with something else, it does not limit the rights of self-organization or collective bargaining protected by the NLRA, and is not pre-empted by that Act." *Id.*

Michigan's Act 429, like Massachusetts' mandated-benefit law, evolved out of the state's concern for the welfare of its citizens. Like the Massachusetts law, Act 429 "does not limit the rights of self-organization or collective bargaining protected by the NLRA," *Id.* Therefore, on the authority of ***Metropolitan Life Insurance Company*** v. ***Massachusetts***, we hold that Act 429 is not pre-empted by the NLRA.

IV.

In conclusion, we hold that Michigan's Act 429 is not preempted by either ERISA or the NLRA. Consequently, we reverse the district court's grant of the plaintiffs' motion for summary judgment and remand the cause to the district court for further proceedings consistent with this opinion.

B. Opinion of the United States District Court, Eastern District of Michigan, Southern Division, *Michigan United Food and Commercial Workers Unions and Food Employers Health and Welfare Fund, et al.* v. *Nancy A. Baerwaldt, et al.*, 572 F. Supp. 943, Case No. 82-73821, as amended September 28, 1983.

Civ. A. No. 82-73821
UNITED STATES DISTRICT COURT,
E.D. MICHIGAN, S.D.
June 16, 1983.
As Amended Sept. 28, 1983.

MICHIGAN UNITED FOOD AND COMMERCIAL WORKERS UNIONS and Food Employers Health and Welfare Fund, et al., Plaintiffs,

v.

NANCY A. BAERWALDT, Commissioner of Insurance of the State of Michigan, et al., Defendants.

Theodore Sachs, I. Mark Steckloff, Detroit, Mich., for plaintiffs.

Harry G. Iwasko Jr., William A. Chenoweth, Lansing, Mich., for defendants.

OPINION

FEIKENS, Chief Judge.

This suit is before me on defendants' motion to dismiss the complaint and plaintiffs' motion for summary judgment. At issue here are questions of federal jurisdiction and ERISA[1] preemption.

I. FACTUAL BACKGROUND

Plaintiffs are health and welfare benefit trust funds established under the Labor Management Relations Act of 1947 ("LMRA"), 29 U.S.C. § 186(c), and subject to ERISA.[2] Defend-

[1]The Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001 *et seq.*

[2]29 U.S.C. §§ 1002(1), (37), and 1003 provide for the plans' coverage.

ants are the Michigan Commissioner of Insurance, two deputy commissioners, and the Michigan Bureau of Insurance. Plaintiffs bring suit for declaratory and injunctive relief.

In 1980, the Michigan Insurance Code was amended by the addition of 1980 P.A. 429 (M.C.L.A. §§ 500.3425, 500.3609 and 500.3609a), which requires that all group disability insurance policies issued, delivered, or renewed in Michigan include a certain amount of coverage for substance abuse treatment. Although plaintiffs have obtained some coverage for substance abuse treatment in their existing policies, the coverage provided does not meet the requirements of the 1980 Act. Plaintiffs ask that the 1980 statute be declared unconstitutional as applied to them, and that defendants be enjoined from its enforcement.

Plaintiffs each have contracts with Occidental Life Insurance Company ("Occidental") providing that each fund will be liable for the payment of benefits to covered employees up to a maximum dollar amount. Once that amount has been exceeded, Occidental assumes responsibililty for benefit payments. This arrangement is sometimes called a "stop-loss" plan. Occidental also administers the plans as agent for the funds.

No actions against either plaintiffs or Occidental have been brought by the Michigan Attorney General's Office.

II. THE MOTIONS

Plaintiffs' summary judgment motion urges that 1980 P.A. 429 is preempted by ERISA, and is therefore unconstitutional under the Supremacy Clause of the Federal Constitution.[3] Plaintiffs also argue that even if ERISA does not preempt 1980 P.A. 429 when it is applied to benefit coverage provided by Occidental, it cannot be applied to that portion of plaintiffs' plans which is self insured.

Defendants' motion to dismiss has two principal compo-

[3]At oral argument, plaintiffs also urged preemption by virtue of the National Labor Relations Act ("NLRA"), 29 U.S.C. § 151 *et seq.*

nents: First, they claim that federal subject matter jurisdiction has not been properly invoked. Second, defendants say plaintiffs have failed to state a claim because ERISA by its own terms saves the Michigan statute, which they say regulates insurance, from preemption.

Deciding the jurisdictional question first, I find that I may properly consider the complaint brought before me. On the merits, I hold that ERISA preempts 1980 P.A. 429 as applied to plaintiffs via their purchase of excess liability insurance from Occidental. My reasons for these holdings follow.

III. THE JURISDICTIONAL QUESTION

Defendants assert that in bringing this action, plaintiffs cannot convert what would be a defense in a state suit into a ground for federal question jurisdiction. Thus, defendants say, plaintiffs have not properly pleaded jurisdiction in this court pursuant to 28 U.S.C. §§ 1331 or 1337.[4] Both because I find the complaint in this suit is not a preemptive strike, and because I believe ERISA gives plaintiffs an independent basis for suit, I reject defendants' argument.

Federal question jurisdiction must be founded upon the allegations in a complaint, not on defenses to the action that might be raised. *Gully v. First National Bank*, 299 U.S. 109, 57 S.Ct. 96, 81 L.Ed. 70 (1936). Defendants properly observe that this rule should not be subverted by potential defendants enterprising enough to start a declaratory or injunctive lawsuit before they are sued. Thus, where there is a preemptive strike, courts do not look to the allegations of the complaint, but the nature of the threatened action. The United States

[4]28 U.S.C. § 1331 provides: "The district courts shall have original jurisdiction of all civil actions arising under the Constitution, laws or treaties of the United States." 28 U.S.C. § 1337(a) provides in part: "The district courts shall have original jurisdiction of any civil action or proceeding arising under any Act of Congress regulating commerce . . ." ERISA is "an Act of Congress regulating commerce," (See 29 U.S.C. § 1001(b), (c)). If the suit before me "arises under" ERISA, therefore, jurisdiction is conferred by either 28 U.S.C. §§ 1331 or 1337(a).

Court of Appeals for the Sixth Circuit recognized this rule in *Michigan Savings & Loan League v. Francis,* 683 F.2d 957 (6th Cir.1982).

In *Francis,* the Sixth Circuit affirmed the lower court's dismissal of the action for lack of jurisdiction. *Francis* was brought by a group of federally chartered savings and loan associations which wanted to avoid being subject to Michigan's Mortgages Lending Act. Plaintiffs alleged the federal Home Owners Loan Act ("HOLA") preempted the Michigan statute. At the time they brought the action, plaintiffs had already been notified that they would be fined by Michigan's Commissioner for Financial Institutions. HOLA has no specific preemption language. Judge Keith, relying on *Public Service Commission v. Wycoff Company, Inc.,* 344 U.S. 237, 73 S.Ct. 236, 97 L.Ed. 291 (1952),[5] held that the federal right asserted was really in the nature of a defense to the imminent state court action, and that therefore federal question jurisdiction was lacking.

Francis is distinguishable from the instant case. First, the HOLA statute before Judge Keith and the ERISA statute before me are dissimilar, inasmuch as ERISA has express language of preemption, where HOLA does not. Second, in the

[5]In *Wycoff,* the Supreme Court held that a company in the business of distributing films within and outside the State of Utah could obtain neither a declaration that its transportation of films within Utah was in furtherance of interstate commerce, nor an injunction preventing Utah's Public Service Commission from interfering with their film distribution. Observing that no state suit had yet been launched, the Court emphasized that the controversy was not ripe for review, and that no showing of irreparable harm had been made. The Court also observed as a general proposition:

> Where the complaint in an action for declaratory judgment seeks in essence to assert a defense to an impending or threatened state court action, it is the character of the threatened action, and not of the defense, which will determine whether there is a federal question jurisdiction. . . . If the cause of action, which the declaratory defendant threatens to assert, does not itself involve a claim under federal law, it is doubtful if a federal court may entertain an action for a declaratory judgment establishing a defense to that claim.

Id. at 248, 73 S.Ct. at 242.

Francis case, a state court suit against plaintiffs was in the offing. Here, no state court determination is being derailed; plaintiffs are not threatened with suit and are not even the potential defendants to such an action. It is Occidental which is the potential defendant. Because Occidental has chosen to avoid the risk of state prosecution under 1980 P.A. 429 by forcing plaintiffs to pay for increased substance abuse coverage, plaintiffs are in effect being saddled with what the consequences of a negative state court determination against Occidental would be, without having the opportunity to litigate their position.

Unlike the situation in *Public Service Commission v. Wycoff, supra*, fn 4, this controversy is ripe for review. Where, as here, plaintiffs base their complaint for both declaratory and injunctive relief from a state statute upon a claim of federal preemption, I hold that plaintiffs are seeking to vindicate a federal right, not just ward off a state suit. *See Stone & Webster Engineering Corporation v. Ilsley*, 690 F.2d 323 (2d Cir.1982). They therefore have properly pleaded federal question jurisdiction under 28 U.S.C. §§ 1331 and 1337.

I also hold that plaintiffs have standing,[6] and have alleged a valid alternative source of jurisdiction. ERISA states that a civil action may be brought

> by a participant, beneficiary or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violation or (ii) to enforce any provisions of this subchapter or the terms of the plan . . . 29 U.S.C. § 1132(a)(3),

and that

> [T] district courts of the United States shall have juris-

[6]This discussion addresses the jurisdictional issue as argued and briefed, notwithstanding the entry of an April 11, 1983 stipulation and order adding the plans' trustees as parties which may have mooted the following points.

> diction, without respect to the citizenship of the parties, to grant the relief provided for in subsection (a) of this section in any action. 29 U.S.C. § 1132(f).

Defendant challenges the applicability of this ERISA provision, saying plaintiff employee benefit plans are not "participants," "beneficiaries" or "fiduciaries" under its language.

I do not read the quoted provision in such a limiting manner. While participants, beneficiaries, and fiduciaries who might otherwise not clearly have standing to bring suit in federal court to enjoin violations of the Act are the only parties addressed, I do not believe the provision's language should be read to exclude a non-fiduciary plan itself from suing for an injunction, and obtaining federal jurisdiction by presenting a question arising under ERISA. ERISA § 1132(d)(1) buttresses the plan's standing. It provides: "an employee benefit plan may sue or be sued under this subchapter as an entity." Although this later provision does not confer federal jurisdiction, and does not define the types of suits which may be brought by a plaintiff plan, I read it, together with § 1132 and ERISA's clear legislative preemption mandate, to sanction the type of suit brought before me.[7]

IV. ERISA PREEMPTION

Three ERISA clauses are the battleground for the parties' preemption dispute. They are commonly known as: (1) the preemption cluase; (2) the "saving" clause; and (3) the "deemer" clause. In order, they provide as follows:

1. *Preemption Clause*

> Except as provided in subsection (b) of this section, the provisions of this subchapter . . . shall supersede

[7]My conclusion is consistent with that reached by the United States Court of Appeals for the Ninth Circuit in *Fentron Industries, Inc. v. National Shopmen Pension Fund*, 674 F.2d 1300 (9th Cir. 1982). The court in *Fentron* specifically found that an employer had standing to assert its claim under ERISA, despite § 1132(e)(1)'s omission of "employers" from the list of those with standing to sue under ERISA.

> any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) . . . and not exempt under section 1003(b) . . . 29 U.S.C § 1144(a).
>
> 2. *Saving Clause*
>
> Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities. 29 U.S.C. § 1144(b)(2)(A).
>
> 3. *Deemer Clause*
>
> (B) Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State, purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.[8] 29 U.S.C. § 1144(b)(2)(B).

Defendants' position is that even if 1980 P.A. 429 "relates to" an employee benefit plan so as to come under the broad preemption of the preemption clause, the statute is "saved" by the clause which excepts laws regulating insurance from invalidity. Plaintiffs read the deemer clause to prevent employee benefit plans from being regulated as if they were insurance companies, but do *not* read it to preclude even indirect effects of insurance laws. Primarily, defendants see the deemer clause as preventing employee benefit plans from being saddled with the regulations insurance companies are prey to; the deemer

[8]Also relevant to the preemption issue are the recent amendments to Section 1144, which will be discussed *infra*. Neither party cited these amendments in its briefs.

clause does not, in defendants' view, make employee benefit plans into a special class of customer for insurance companies. As additional authority, defendants cite the McCarran-Ferguson Act, 15 U.S.C. § 1011 *et seq.*, which states in part "No act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance . . . unless such act specifically relates to the business of insurance . . ." 15 U.S.C. § 1012(b). ERISA § 1144(d) provides that ERISA does not modify or supersede any other federal law.

Plaintiffs' position is that enforcement of the 1980 Act would regulate the terms and conditions of plaintiffs' plans. Plaintiffs assert that neither direct nor indirect regulation is permissible. They read the deemer clause as making clear that states cannot prescribe plan terms in the guise of regulating insurance. Plaintiffs point out that if the deemer, saving, and preemption clauses allow for an act like 1980 P.A. 429, then the only option for plans hoping to avoid mandatory forms of coverage imposed by states would be to be self insured. Plans would then differ in the requirements made of them by virtue of their capacity to self insure. This would defeat ERISA's goal of uniform standards applicable to all employee benefit plans.

As a final point, plaintiffs say that even if 1980 P.A. 429 is permissible when invoked against an insurance company which offers group life coverage to an ERISA plan, it should not apply to a self-insured plan. They characterize their stop-loss coverage as being, in effect, self insurance up to the maximum loss figure when Occidental begins to assume coverage. Because of my holding in this case, I do not reach this last issue.

V. ANALYSIS

I agree with plaintiffs' view that the statute in question impermissibly dictates the terms and conditions of an employee benefit plan. I believe that ERISA was intended to insulate

multi-employer welfare benefit plans formed pursuant to collective bargaining agreements from any state laws that might prescribe the benefits they are to afford. Although the broad stroke of § 1144's preemption clause is modified by the saving clause's caveat that "nothing in this title shall be construed to exempt or relieve any person[9] from any law of any state which regulates insurance, banking, or securities," I do not think that clause was aimed at preserving state statutes which more than tangentially affect employee benefit plans.

ERISA's language and legislative history make clear that it was enacted to help insure employees a certain modicum of security in the expectation of benefits they held from private pension and welfare plans. It is also apparent that ERISA was carefully devised to insure that the regulations it imposed upon employee pension and benefit plans would not strangle the growth of these plans.[10] Implicit in the whole purpose of

[9]"Person" is defined in ERISA as "an individual, partnership, joint venture, corporation, mutual company, joint-stock company, trust, estate, unincorporated organization, association, or employee organization." 29 U.S.C. § 1002(9). I note that the meaning of "trust" in this list is somewhat ambiguous, and I have some doubt as to whether the employee benefit plans before me were meant to fall within the definition of "person" at all.

[10]In its synopsis of ERISA's purposes, the House Committee on Education and Labor (hereinafter "House Committee") observed:

> The Employee Benefit Security Act as reported by the Committee is designed to remedy certain defects in the private retirement system which limit the effectiveness of the system in providing retirement income security. The primary purpose of the bill is the protection of individual pension rights, but the committee has been constrained to recognize the voluntary nature of private retirement plans. The relative improvements required by this Act have been weighed against the additional burdens to be placed on the system. While modest cost increases are to be anticipated when the Act becomes effective, the adverse impact of these increases have been minimized. Additionally, all of the provisions in the Act have been analyzed on the basis of their projected costs in relation to the anticipated benefit to the employee participant. In broad outline, the bill is designed to:
>
> (1) establish equitable standards of plan administration;
>
> (2) mandate minimum standards of plan design with respect to the vesting of plan benefits;

the Act is a desire to encourage private pension and welfare plans by promulgating uniform, reasonable, and non-oppressive federal requirements.

In my view, this nurturant attitude towards private plans must be carefully considered in determining the preemption issue before me. Preemption of a state statute is demanded by the Supremacy Clause of the United States Constitution (Art. VI, Cl. 2) where state and federal laws are inconsistent. A state law need not directly contradict a federal statute to be preempted; state laws which impinge on an area carved out by Congress as an exclusive federal domain are unenforceable as well. *Fidelity Savings & Loan Ass'n v. de la Cuesta*, 458 U.S. 141, 102

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(3) require minimum standards of fiscal responsibility by requiring the amortization of unfunded liabilities;

(4) insure the vested portion of unfunded liabilities against the risk of premature plan termination; and

(5) promote a renewed expansion of private retirement plans and increase the number of participants receiving private retirement benefits.

H.R. Rep. No. 533, 93 Cong., 2d Sess. (hereinafter "House Report"), reprinted in 1974 U.S. Code Cong. & Ad.News 4639-40, continues:

The Committee believes that the legislative approach of establishing minimum standards and safeguards for private pensions is not only consistent with retention of the freedom of decision-making vital to pension plans, but in furtherance of the growth and development of the private pension system. At the same time, the Committee recognizes the absolute need that safeguards for plan participants be sufficiently adequate and effective to prevent the numerous inequities to workers under plans which have resulted in tragic hardship to so many.

The Bill reported by the Committee represents an effort to strike an appropriate balance between the interests of employers and labor organizations in maintaining flexibility in the design and operation of their pension programs, and the need of the workers for a level of protection which will adequately protect their rights and just expectations. In adopting this approach, the Committee believes it has designed a bill, which, like the National Labor Relations Act, the wage-hour laws and other labor standards laws, brings the workers' interests up to parity with those of employers. This legislation strikes an appropriate and equitable balance between two opposing schools of thought — those who advocate complete and stringent control of private pensions and those who oppose any form of government supervisory or regulatory control.

House Report, Op. Cit., at 4647.

S.Ct. 3014, 73 L.Ed.2d 664 (1982); *Malone v. White Motor Corp.*, 435 U.S. 497, 98 S.Ct. 1185, 55 L.Ed.2d 443 (1978); *Kapuscinski v. Plan Administrator, et al.*, 658 F.2d 427 (6th Cir. 1981); *Carpenters Pension Trust for Southern California v. Kronschnabel*, 460 F.Supp. 978 (C.D.Cal.1978), *aff'd* 632 F.2d 745 (9th Cir.1980). By generally disallowing state regulations that might enhance protections for employees within any particular state, Congress was making a judgment that the greater national good called for both a minimum and maximum on the regulation of employee benefit plans.[11]

Informed as I am by the general intent of ERISA, I would construe the saving and deemer clauses differently than some of my fellow judges have done.[12] Certain other courts, when

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[11]Discussing preemption, Congressman Dent said in the final House debate on the Bill, "I wish to make note of what is to many *the crowning achievement of this legislation, the reservation to Federal authority of the sole power to regulate the field of employee benefit plans.* With the preemption of the field, we round out the protection afforded participants by eliminating the threat of conflicting and inconsistent State and local regulation." 120 Cong.Rec. (HR) 29197 (August 20, 1974) (emphasis supplied), *quoted in General Motors Corp. v. Buha*, 623 F.2d 455, 459 (6th Cir.1980). This was not the case when the Supreme Court considered the preemptive effect of the federal Welfare and Pensions Plan Disclosure Act (superseded) in *Malone v. White Motor Corp.*, 435 U.S. 497, 98 S.Ct. 1185, 55 L.Ed.2d 443 (1978). There, the Court refused to find that that statute, ERISA's predecessor, and the NLRA preempted state regulation of pension plans. Instead, the Court pointed to language in the legislative history of that Act which indicated Congress "envisioned the exercise of state regulation over pension funds." 435 U.S. 497, 512, 98 S.Ct. 1185, 1194, 55 L.Ed.2d 443. The court in *Malone* noted, however, that Congress "came to a quite different conclusion" where ERISA was concerned. According to the Court's dicta, ERISA was enacted largely in response to perceived inadequacies in the prior scheme.

[12]I come to the saving clause directly, rather than discussing the preemption clause at length, because I think it is clear that 1980 P.A. 429 "relates to" an employee welfare benefit plan, and is thus preempted *unless* it falls under the enumerated exceptions of the saving clause. As the Court of Appeals for the Second Circuit observed in *Stone & Webster Engineering Corp. v. Ilsley, supra*, "A state law 'relates to' an employee benefit plan and is subject to preemption whenever it 'purports to regulate, directly or indirectly, the terms and conditions of employee benefit plans.' " *Id.* at 329, *quoting* from 29 U.S.C. § 1144(c)(2). I note that defendants all but conceded the relatedness of the statute in question in their brief.

faced with statutes denominated insurance regulations, have been loath to allow preemption when these statutes were applied against an insurance company, rather than directly against a plan.

In *Wadsworth v. Whaland,* 562 F.2d 70 (1st Cir.1977), for example, the First Circuit held that a New Hampshire statute requiring all group health insurance policy issuers to provide policy coverage for mental illness was not preempted.[13] Plaintiffs in *Wadsworth* had contended that the statute "impermissibly regulate[d] employee benefit plans by indirectly regulating the content of the group insurance policies which the funds purchase, and that ERISA preempt[ed] any state regulation of employee benefit plans. The State of New Hampshire respond[ed] that ERISA was not intended to preempt any state law unless that law directly conflict[ed] with or duplicate[d] the regulatory provisions of ERISA." *Id.* at 76.

Rejecting plaintiff's argument, the court in *Wadsworth* construed the deemer clause as prohibiting only the *direct* regulation of an employee benefit plan as an insurance company, and found that the saving clause would be meaningless without including the New Hampshire statute under its protection. I disagree.

Unlike the court in *Wadsworth*, I do not view the saving and deemer clauses as preserving a back door approach to control of a plan's terms and conditions through "indirect" regulation. If Congress had meant for the deemer clause to have such consequences, it would have used more specific language.[14] Furthermore, the distinction between direct versus indirect

[13] *See also Attorney General v. Travelers Insurance Co.,* 385 Mass. 598, 433 N.E.2d 1223 (1982); *cf. General Split Corp. v. Mitchell,* 523 F.Supp. 427, 431 (E.D. Wis. 1981); and *Russo v. Boland,* 103 Ill.App.3d 905, 59 Ill.Dec. 537, 431 N.E.2d 1294 (1982).

[14] In the 1983 Amendments to § 1144, in fact, Congress does distinguish between some fully insured and non-fully insured plans, but its distinction does not affect plans like the one before me.

regulation has been rejected, albeit in cases not involving the saving and deemer clauses but only the preemption clause, by the Supreme Court and the Court of Appeals for the Sixth Circuit.[15] There are sound public policy reasons for rejecting the distinction. As the court in *Metropolitan Life Insurance Company v. Insurance Comm'r,* 51 Md.App.122, 441 A.2d 1098 (Spec.App.1982), noted:

> Although it was the clear intent of the Congress not to interfere in the regulation of insurance by the states, we see no intent to extend that policy to permitting state regulation of the terms and conditions of employee benefit plans. [One article treating the subject] observes:
>
> > If states are permitted to require employee benefit plans to provide substantive benefits under the guise of insurance regulation, the result may be a Hobson's choice for employee or labor and management negotiators; either abandon the funding of benefit plans through insurance policies or be willing to accept all-encompassing uniform national contracts. For, if each state may impose its own substantive terms on the plan, the only way uniformity may be reached is by incorporating into the plan all of the benefits each state requires. This dilemma is clearly of the type that Congress sought to avoid by enacting ERISA's preemption provisions, which were formulated to re-

[15]In *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 101 S.Ct. 1895, 68 L.Ed.2d 402 (1981), the Supreme Court struck down a New Jersey statute prohibiting employers from setting off workers' compensation awards in their provision of pension benefits. The Court found that Congress meant to preempt the field of pension plan regulation when it adopted ERISA. The New Jersey statute, although called a workers' compensation law rather than a pension plan regulation, could not escape preemption. "ERISA's authors clearly meant to preclude the States from avoiding through form the substance of the preemption provision." *Id.* at 525, 101 S.Ct. at 1907. "It is of no moment that New Jersey intrudes indirectly . . . rather than directly." *Id. See also Kapuscinski v. Plan Administrator,* 658 F.2d 427 (6th Cir. 1981).

> lieve interstate employee benefit plans of the adverse effects of cumulative or inconsistent state regulation.

Id. 441 A.2d at 1103, *quoting* Hutchinson and Ifshin, *Federal Preemption of State Law Under the Employee Retirement Income Security Act of 1974,* 46 Chicago L.Rev. 23, 68-69 (1978).

Looking at the saving clause as a whole, I find that its purpose was to avoid unintended and wholesale preemption of important fields of state concern by making clear that statutes only incidentally affecting employee benefit plans, but not regulating their terms and conditions, were not to be ousted. In other words, ERISA's preemption clause was not meant to sweep up within it a whole range of state laws that were or could arguably be related to employee benefit plans, but were actually addressed to maintaining state control over three areas of its traditional power: banking, securities regulation, and the regulation of insurance.

The saving clause may preserve the state's power to regulate certain types of institutions important to the fabric of state life, and generally excluded from fedral regulation, but I would confine the term "regulates insurance" so as to exclude laws which do not so much monitor the insurance industry as its customers from the clause's protection.[16] As the House Committee on Labor and Education observed in a report prepared pursuant to its oversight responsibility for ERISA:

> The provisions of Section [1144] expressly reserve to federal authority the regulation of employee benefit plans subject to the jurisdiction of the Act. In electing deliberately to preclude State authority over these plans, Congress acted to insure uniformity of regulation with respect to their activities. There was a recognition of the necessity for the preservation of some State activity in this field and certain limited exceptions were made to

[16]By doing so, I believe I strike the correct balance between the McCarran-Ferguson Act and ERISA.

> the broad preemption scheme. *In general these exemptions are designed to save State law as it applies to entities which are not employee benefit plans as defined in Section [1003(a)] and not exempt under Section [1003(b)], to the extent that such regulation does not relate to employee benefit plans.* ACTIVITY REPORT OF THE COMMITTEE ON EDUCATION AND LABOR OF THE U.S. HOUSE OF REPRESENTATIVES, House Report No. 94-1785, pp. 46-47 (1/3/77), *quoted in Bell v. Employee Security Benefit Ass'n,* 437 F.Supp. 382, 387 (D.Kan.1977). (Emphasis added.)

Not every statute designated an insurance law should come within the exception carved out by Congress to ERISA's broad preemption. There are laws, however, which are more than just nominally insurance regulations. Laws which increase the cost of doing business for an insurance company may relate to or affect a plan but yet be unimpeachable because they do in fact "regulate insurance" and only tangentially affect plans; with non-preemption of such laws I would have no quarrel.

My view is supported by a reading of the saving clause in tandem with the deemer clause. I consider the deemer clause to have two main purposes. First, the clause makes clear that employee benefit plans should not be viewed as the equivalents of insurance companies, securities firms, or banks simply because they might serve some of the same functions for their beneficiaries. They are thus not subject to the same kind of *institution qua institution* regulations. Second, the clause prevents the above-mentioned institutions from "masquerading" as employee benefit plans, and thus avoiding state regulations having nothing directly to do with ERISA or the private pension and welfare benefit system. *See,* for example, *Hamberlin v. VIP Insurance Trust,* 434 F.Supp. 1196 (D.Ariz.1977); *Wayne Chemical Inc. v. Columbus Agency Service Corporation,* 567 F.2d 692 (7th Cir.1977).

Congress' newly enacted legislation also bolsters my conviction that the types of plans plaintiffs represent are immune from the permissible regulation of insurance left open by the saving clause.

Section 1144 now includes the following language:

> (6)(A) Notwithstanding any other provision of this section —
>
> (i) in the case of an employee welfare benefit plan which is a multiple employer welfare arrangement and is fully insured . . . any law of any State which regulates insurance may apply to such arrangement to the extent that such law provides —
>
> (I) standards, requiring the maintenance of specified levels of reserves and specified levels of contributions . . . and
>
> (II) provisions to enforce such standards, and
>
> (ii) in the case of any other employee welfare benefit plan which is a multiple employer welfare arrangement, . . . any law of any State which regulates insurance may apply to the extent not inconsistent with the preceding sections of this subchapter . . .
>
> (C) Nothing in subparagraph (A) shall affect the manner or extent to which the provisions of this subchapter apply to an employee welfare benefit plan which is not a multiple employer welfare arrangement and which is a plan, fund, or program participating in, subscribing to, or otherwise using a multiple employer welfare arrangement to fund or administer benefits to such plan's participants and beneficiaries . . .

At first blush, this new language might seem to support the rationale of cases finding against preemption when a statute has a direct coercive effect only upon an insurance company, but not a plan.[17] Fully insured multi-employer welfare arrange-

[17] *See* n. 13, *supra.*

ments are treated differently from non-fully insured arrangements under the § 1144 amendments. The fully insured arrangements are specifically subject to a range of state laws presumably narrower than those provided in the saving clause, whereas the non-fully insured arrangements are subject to any state laws which "regulates insurance," unless the Secretary exempts them from coverage. What constitutes regulation of insurance is not more clearly defined than in the original language of § 1144, leaving open the possibility that statutes affecting terms and conditions of multi-employer welfare benefit "arrangements" might be "saved" from preemption.

Nevertheless, I read the new statutory language to support plaintiffs' position. In an amendment to the definitional section of the Act, "multi-employer benefit arrangement" is defined in pertinent part as:

> [A]n employee welfare benefit plan, or any other arrangement (other than an employee welfare benefit plan), which is established or maintained for the purpose of offering or providing any benefit described in paragraph (1)[18] to the employees of two or more employers (including one or more self-employed individuals), or to their beneficiaries, except that such term does not include any such plan or other arrangement which is established or maintained—
>
> (i) under or pursuant to one or more agreements which the Secretary finds to be collective bargaining agreements . . . 29 U.S.C. § 1002(40)(A).

By contrast, a "multi-employer plan" is defined as one:

> (i) to which more than one employer is required to contribute,
>
> (ii) which is maintained pursuant to one or more collective bargaining agreements between one or more employee organizations and more than one employer, and

[18] 29 U.S.C. § 1002(1).

(iii) which satisfies such other requirements as the Secretary may prescribe by regulation. 29 U.S.C. § 1002(37)(A).

Thus, plans like plaintiffs' which were established pursuant to a collective bargaining agreement form a separate class, treated differently under the Act. The new statutory language affecting multi-employer benefit plans *not* formed pursuant to a collective bargaining agreement does not reach the plans before me.

Congress had good reason for differentiating between plans which conform to a collective bargaining agreement and those which do not. First, the benefits under plans formed as a result of collective bargaining express the finely tuned give and take of the negotiating process. Second, such plans embody the goals of the NLRA, a federal statute which in and of itself has preemptive effect. As the Supreme Court observed in *Alessi v. Raybestos-Manhattan, Inc., supra*, "Employee benefit plan terms themselves become expressions of federal law, requiring preemption of intrusive state law." *Id.* 451 U.S. at 536, 101 S.Ct. at 1913.

The fact that the state law in question reflects the benign public policy of alleviating alcohol and drug dependencies is not enough to allow evisceration of the agreement embodied in the employee benefit plans before me.[19] As one court observed, "Ordinarily, preemption depends upon the effect of State law upon NLRA policy, and the fact that a state law is enacted for

[19] *Cf. Local 24, International Board of Teamsters v. Oliver*, 358 U.S. 283, 79 S. Ct. 297, 3 L.Ed.2d 312 (1959), where the Supreme Court held that Ohio's antitrust law was preempted insofar as it interfered with a collectively bargained wage agreement, but also noted that the statute before it was not a "local health or safety regulation." *Id.* at 297, 79 S.Ct. at 305. 1980 P.A. 429 is not, in my estimation, the type of "local health or safety regulation" which the *Oliver* court expressed doubt about preempting. It is not a regulation designed to deal with emergency situations and imminent threats to public health, which are so peculiarly within the police power of the state to address. Thus, I view *Oliver* as supporting preemption under the NLRA.

neutral purposes and applies outside the employment relationship cannot save it from preemption." *Attorney General v. Travelers Insurance Co.*, 385 Mass. 598, 433 N.E.2d 1223 (1982) 433 N.E.2d at 1231-1232.[20] Public Act 429 of 1980 disturbs a mandatory subject of collective bargaining; namely, the provision of health benefits. Because of its effect, it must be preempted.[21]

For the reasons stated above, I hold that 1980 P.A. 429 is preempted as it applies to multi-employer welfare benefit plans subject to ERISA, and that the State of Michigan is permanently enjoined form its enforcement against such plans.

An appropriate order may be submitted.

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[20]In *Attorney General v. Travelers Insurance Co., supra*, the Supreme Court of Massachusetts found no preemption when faced with a similar statute. The Court relied upon three grounds for rejecting preemption: first, it found that the state law in question was of special local concern, and was not the type of law Congress contemplated preempting under the NLRA; second, as a state regulation of insurance, the law came under the protection of the McCarran-Ferguson Act, *supra*, "which establishes a congressional policy in favor of State regulation of insurance," Id. 433 N.E.2d at 1232; and finally, the statute did not directly prohibit plans from retaining the level of health benefits they had contemplated, but only imposed different benefits upon plans which sought insurance. I reject all three reasons offered against preemption. First, as I have already noted, I distinguish the type of statute before me from the type of health and public safety law the *Oliver* court recognized might not be preempted. Second, I read the McCarran-Ferguson Act, which provides for state regulation of the "business of insurance" to apply to a narrower range of state activity when read in light of ERISA. Third, I do not believe plans entered into as a result of collective bargaining should be presented with the dilemma of choosing between acquisition of insurance, and maintenance of their agreed-upon terms and conditions.

[21]Preemption by virtue of the NLRA provides an alternative basis for my holding in this case. Because the NLRA issue was raised only at oral argument, and not in plaintiffs' brief, defendants may feel disadvantaged inasmuch as they did not have a full opportunity to research NLRA preemption. Any disadvantage defendants may have suffered in presenting such an argument is of no consequence, however, because my decision to preempt stands equally upon ERISA's mandate.

C. Judgment of the United States Court of Appeals for the Sixth Circuit, *Michigan United Food and Commercial Workers Unions and Food Employers Health and Welfare Fund, et al.* v. *Nancy A. Baerwaldt, et al.*, Case No. 83-1570, entered July 19, 1985.

UNITED STATES COURT OF APPEALS
For the Sixth Circuit
No. 83-1570

MICHIGAN UNITED FOOD AND COMMERCIAL WORKERS UNIONS AND FOOD EMPLOYERS HEALTH AND WELFARE FUND, et al.,

Plaintiffs-Appellees,

v.

NANCY A. BAERWALDT, Commissioner of Insurance of the State of Michigan, et al.,

Defendants-Appellants.

Before: KEITH, Circuit Judge; and PECK and BROWN, Senior Circuit Judges.

JUDGMENT

ON APPEAL from the United States District Court for the Eastern District of Michigan.

THIS CAUSE came on to be heard on the record from the said District Court and was argued by counsel.

ON CONSIDERATION WHEREOF, It is now here ordered and adjudged by this court that the judgment of the said District Court in this case be and the same is hereby reversed and the case is remanded for further proceedings consistent with this opinion.

It is further ordered that Defendants-Apellants recover from Plaintiffs-Appellees the costs on appeal, as itemized below, and that execution therefor issue out of said District Court, if necessary.

ENTERED BY ORDER OF THE COURT
John P. Hehman, Clerk

D. Text of 1980 PA 429, Michigan Comp. Laws Ann. §§ 500.3425, .36092(a).

500.3425. *Substance abuse care coverage*

Sec. 3425. (1) Required coverage. Each insurer offering health insurance policies in this state shall provide coverage for intermediate and outpatient care for substance abuse, upon issuance or renewal, in all contracts for, group and individual hospital, medical, surgical expense-incurred health policies other than limited classification policies.

(2) Option to decline coverage. In the case of group health insurance policies, if the premium for a group health insurance policy would be increased by 3% or more because of the provision of the coverage required under subsection (1), the master policyholder shall have the option to decline the coverage required to be provided under subsection (1). In the case of individual health insurance policies, if the total premium for all individual health insurance policies of an insurer would be increased by 3% or more because of the provision of the coverage required under subsection (1) in all of those policies, the named insured of each such policy shall have the option to decline the coverage required to be provided under subsection (1).

(3) Charges, terms, conditions. Charges, terms, and conditions for the coverage required to be provided under subsection (1) shall not be less favorable than the maximum prescribed for any other comparable service.

(4) Reduction of coverage by policy terms and conditions; deductibles and copayment. The coverage required to be provided under subsection (1) shall not be reduced by terms or conditions which apply to other items of coverage in a health insurance policy, group or individual. This subsection shall not be construed to prohibit health insurance policies that provide for deductibles and copayment provisions for coverage for intermediate and outpatient care for substance abuse.

(5) Minimum benefits. The coverage required to be provided under subsection (1) shall, at a minimum, provide for up to $1,500.00 in benefits for intermediate and outpatient care for substance abuse per individual per year. This minimum shall be adjusted annually by March 31 each year in accordance with the annual average percentage increase or decrease in the United States consumer price index for the 12-month period ending the preceding December 31.

(6) Definitions. As used in this section:

(a) "Health insurance policy" means a hospital, medical, or surgical expense incurred policy.

(b) "Intermediate care" means the use, in a full 24-hour residential therapy setting, or in a partial, less than 24-hour, residential therapy setting, of any or all of the following therapeutic techniques, as identified in a treatment plan for individual physiologically or psychologically dependent upon or abusing alcohol or drugs:

(i) Chemotherapy.

(ii) Counseling.

(iii) Detoxification services.

(iv) Other ancillary services, such as medical testing, diagnostic evaluation, and referral to other services identified in a treatment plan.

(c) "Limited classification policy" means an accident only policy, a limited accident policy, a travel accident policy, or a specified disease policy.

(d) "Outpatient care" means the use, on both a scheduled and a nonscheduled basis, of any or all of the following therapeutic techniques, as identified in a treatment plan for individual physiologically or psychologically dependent upon or abusing alcohol or drugs:

(i) Chemotherapy.

(ii) Counseling.

(iii) Detoxification services.

(iv) Other ancillary services, such as medical testing, diagnos-

tic evaluation, and referral to other services identified in a treatment plan.

(e) "Substance abuse" means that term as defined in section 6107 of Act No. 368 of the Public Acts of 1978, being section 333.6107 of the Michigan Compiled Laws.

(7) Effective date. This section shall take effect January 1, 1982.

500.3609a. *Substance abuse care coverage*

Sec. 3609a. (1) An insurer which delivers, issues for delivery, or renews in this state a policy of group disability insurance shall offer to include in that policy a provision that the insurer will provide coverage for inpatient care for substance abuse to the extent agreed upon between the insured employer or other insured organization and the insurer, to be provided in a facility approved by the department of public health for hospitalization or treatment of substance abuse. This coverage shall be subject to the provisions of sections 3406 to 3466, except section 3425.

(2) An insurer which delivers, issues for delivery, or renews in this state a policy of group disability insurance shall include in that policy a provision that the insurer will provide coverage for intermediate and outpatient care for substance abuse, to the extent required by section 3425.

(3) This section shall take effect January 1, 1982.

E. Text of ERISA, § 514(a)-(d), 29 U.S.C. 1144(a)-(d) (irrelevant portions deleted).

§ 1144. Other laws

(a) Supersedure; effective date

Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

(b) Construction and application

(1) This section shall not apply with respect to any cause of action which arose, or any act or omission which occurred, before January 1, 1974.

(2)(A) Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

(B) Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

* * *

(c) Definitions

For purposes of this section:

(1) The term "State law" includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State. A law of the United States applicable only to the District of Columbia shall be treated as a State law rather than a law of the United States.

(2) The term "State" includes a State, any political subdivisions thereof, or any agency or instrumentality of either, which purports to regulate, directly or indirectly, the terms and conditions of employee benefit plans covered by this subchapter.

(d) Alteration, amendment, modification, invalidation, impairment, or supersedure of any law of United States prohibited

Nothing in this subchapter shall be construed to alter, amend, modify, invalidate, impair, or supersede any law of the United States (except as provided in sections 1031 and 1137(b) of this title) or any rule or regulations issued under any such law.